Jurisdiction 15 Part A Voluntary Overpayment Refund

SHALL BE COMPLETED BY MEDICARE CONTRACTOR

Date

Contractor Deposit Control Number **Date of Deposit**

Contractor Contact Name **Phone Number** **Extension**

Contractor Address

Contractor Fax

SHALL BE COMPLETED BY PROVIDER/PHYSICIAN/SUPPLIER, OR OTHER ENTITY

Please complete and forward to your Medicare contractor. This form, or a similar document containing the following information, should accompany every unsolicited/voluntary refund so that receipt of check is properly recorded and applied.

Provider/Physician/Supplier or Other Entity Name

Address

Provider/Physician/Supplier Number **Tax ID Number**

Contact Person **Phone Number**

Amount of Check $ **Check Number** **Check Date**

REFUND INFORMATION

For each claim, provide the following . . .

Patient Name **Medicare Number**

Medicare Claim Number **Claim Amount Refunded $**

Date of Service

Reason Code for Claim Adjustment

Select reason code from list below. Use one reason per claim.
Please list all claim numbers involved. Attach separate sheet, if necessary.

NOTE - If specific patient Medicare/claim number/claim amount data not available for all claims due to Statistical Sampling, please indicate methodology and formula used to determine amount and reason for overpayment:

NOTE - If specific patient Medicare/claim number information is not provided, no appeal rights can be afforded with respect to this refund. Providers/physicians/suppliers, and other entities who are submitting a refund under the OIG's Self-Disclosure Protocol or who are under a CIA are not afforded appeal rights as stated in the signed agreement presented by the OIG.

For Institutional Facilities Only

Cost Report Year(s)

(If multiple cost report years are involved, provide a breakdown by amount and corresponding cost report year.)

For OIG Reporting Requirements

Do you have a Corporate Integrity Agreement with OIG? ☐ **Yes** ☐ **No**

Are you a participant in the OIG Self-Disclosure Protocol? ☐ **Yes** ☐ **No**

Reason Codes

Billing/Clerical
01 – Corrected Date of Service
02 – Duplicate
03 – Corrected CPT Code
04 – Not Our Patient(s)
05 – Mod. Add/Remove
06 – Billed in Error

MSP/Other Payer Involvement
07 – MSP Group Health Plan Insurance
08 – MSP No Fault Insurance
09 – MSP Liability Insurance
10 – MSP, Workers Comp. (Including Black Lung)
11 – Veterans Administration

Miscellaneous
12 – Insufficient Doc
13 – Patient Enroll HMO
14 – Svcs Not Rendered
15 – Medical Necessity
16 – Other-Please Specify

Note - Please include any additional information needed to correctly adjudicate your claim such as which procedure codes and amounts for items returned, primary insurance Explanation of Benefits and detailed reason for Medical Necessity.

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